State of Tennessee
Department of Health
Board of Examiners in Psychology

(Local) (615) 532-3202 or (Toll Free) (800) 778-4123

www.tennessee.gov

Psychologist Application

Dear Applicant:

This application packet is for those who are applying for a Psychologist license and includes the form for those applying for Heath Service Provider (HSP) designation. The requirements for application are detailed in the enclosed Board Rules and State licensure statutes (Title 63, Chapter 11). Please read instructions, statute and rules carefully to ensure that your application is complete.

All documents submitted to the Board become part of your file and are not returnable or transferable. Your application will be reviewed for completeness and you will be notified when the review is completed. Typically, application materials are in the applicant's file within two weeks of the postmarked date. The Board's administrative staff is dedicated to the professional management of all applicant files. If you would like to personally review your file, please call the board office and make an appointment.

Acceptability of licensure application is a Board decision, not an administrative staff decision. Be aware that the review for completeness of your file does not indicate whether you are accepted as a candidate for licensure. The licensing process includes up to four reviews by the Board. Completion of one review is necessary before proceeding to the next step.

1. Review of the application, applicant's education and training, and other support materials.
2. Review of Examination for Professional Practice in Psychology results.
3. Review Oral Examination committee recommendations.
4. Review of verification of completion of HSP supervised year of experience.

The Board meets regularly throughout the year and at these meetings the Board considers applications, written and oral examination results, and HSP support materials for the purpose of licensure. The Division of Health Related Boards is empowered to issue licenses to those applicants deemed qualified by the Board of Examiners in Psychology. Licenses are generally issued within thirty days of the Board meeting.

Please understand that applicants and licensees have the responsibility to notify the board office whenever a change of name or mailing address occurs. Notification needs to be in writing. Please reference your profession and the board in your correspondence. A change of name request must be notarized and the reason for the change (i.e., marriage, divorce, etc.) needs to be stated.

Every effort will be made to keep you informed of your application's status and to process your application in a timely manner. Inquiries regarding your file will receive a response.

To ensure timely receipt of materials, all information is to be addressed as follows:

Board of Examiners in Psychology
227 French Landing, Suite 300
Heritage Place Metro Center
Nashville, Tennessee 37243

Directions for Application for Licensure

a) You are obligated to complete the application truthfully and completely. To ensure the accurate completion of these forms, it is recommended that you carefully read both the state law and the Board rules before completing this application. In particular, the Rules in 1180-2 provide information that might be helpful in completing your application.

b) Identifying information is requested in **items 1 and 2** on the application form.

c) For **items 3 through 5** please provide information about the license you are seeking. Please see the Rules in 1180-2-.02 for clarification of the terms used in these questions.

d) **Items 6 through 22** are for providing demographic and historical information.

e) **Item 23** is for those applicants that have held a license or certificate to practice psychology in Tennessee or any other North American jurisdiction.

f) For **item 24** you need to provide information about the three individuals whom you have asked to provide the board with letters of recommendation. Rule 1180-2-.03(6) details the credentials that are required for those who write your recommendation letters. Please review this rule before soliciting letters of recommendation.

g) Information about your graduate training is Psychology is requested for **item 25**. See Rule 1180-2-.02 for details about the type of training required for the Psychologist license. If you attended more than one graduate program in psychology, use a separate page to provide information on other institutions.

The issue of designation or accreditation of the degree program only matters for the training program where you completed your doctoral degree or specialty retraining. Please check with the training program if you are unsure about whether your program was accredited by American Psychological Association's (APA) Committee on Accreditation or listed by Council for the Nationally Register of Health Service Providers in Psychology/Association of State and Provincial Boards' (NR/ASPPB) "Designated Doctoral Programs in Psychology" at the time you graduated.

h) If you are applying for the HSP Designation, you need to provide information about your internship for **item 26**. If you are **not** applying for this designation, do not complete this item. Rule 1180-2-.02 details the type of internship is acceptable for HSP Designation. Please check with your internship if you are unsure about whether the internship was accredited by APA's Committee on Accreditation or a member Association of Psychology Postdoctoral and Internship Centers (APPIC).

i) If you are applying for the HSP Designation and you have completed at least one year of post-doctoral supervised experience, you need to provide information about this experience in **item 27**. If you are not applying for this designation or have not yet completed the post-doctoral supervised experience, do not complete this item. Rule 1180-2-.02 details the requirements for this post-doctoral experience. If this postdoctoral year was completed at more than one setting, please use a separate page to provide information on other settings.

j) You are asked to provide information about previous employment where you provided mental health services in **item 28**. You need not include paid or unpaid graduate training-related practicums or placements. If you had more than one mental health employment setting, please use a separate page to provide information on other settings.

k) You need to provide two (2) recent signed passport type photographs. Passport photos are head-and-shoulders pictures. After signing the back of the photos, attach them to the space provided under **item 29**.

l) You have now completed the general application for licensure. This application will need to be signed and notarized. Please be aware that depending on the type of application and your current status in another jurisdiction, you might need to complete additional forms.

m) You need to request that the institution(s) of higher education submit the **transcript(s) of all graduate coursework** directly to the Board office. The transcript needs show the highest degree granted, coursework and credits and must carry the official seal of the institution. Unofficial transcripts are not acceptable.

If the transcript shows that you have completed the required course work but have not received your degree, you need to have the Registrar submit a letter attesting to the date upon which you will graduate, affixed with the seal of the institution. We will use the transcript and letter to complete our initial review of your application. Please remember that a final transcript showing your degree must be received before licensure can be granted.

Foreign trained applicants must send their transcripts to World Education Service, P.O. Box 745, Old Chelsea Station, New York, NY 10113-0745, (212) 966-6311 for assessment and their results must be mailed directly to the Board of Examiners in Psychology, 227 French Landing, Suite 300, Heritage Place Metro Center, Nashville, TN 37243.

Supporting documents such as course descriptions, syllabi, and thesis or dissertation summaries must be supplied in order to determine equivalency of education training.

n) Fees related to all licenses issued by this Board are detailed in Board Rule 1180-1-.03. Payment of the application fee ($175), licensure fee ($200), state regulatory fee ($10), and ethics and jurisprudence exam fee ($200) must accompany your application. Other fees might also need to be paid. **For example, those asking for a Temporary License must pay an additional $100 and those requesting a Provisional License must pay an additional $125.** Please consult Chapter 1180-1 of the Board's Rules in order to determine if you will need to pay any additional fee(s). A personal check or money order should be made payable to the "State of Tennessee." The application fee is non-refundable, however the other fees may be refunded if the application is withdrawn or denied. Please contact the Board administrator if you believe that any fees should be refunded to you. Refunds will take approximately eight weeks to process. You can submit one check to pay all necessary fees.

o) The **written examination**, or EPPP, is a computer delivered 225-item test covering basic psychological science, professional application, ethics, and related considerations in psychology. Information concerning the exam can be obtained by writing to Professional Examination Service (PES), 475 Riverside Drive, New York, New York 10115. Upon approval by the board to take the EPPP the applicant's name will be submitted to the PES. Written authorization for testing will be sent to the applicant by PES with instructions to contact the chosen testing provider and information regarding the exam fee. Information regarding the EPPP can be found in Rule 1180-2-.04.

p) **Ethics and Jurisprudence examinations** will be mailed or scheduled by the Board administrator after it has been determined that you have passed the EPPP. The purpose of the exam is to test your knowledge of Tennessee law related to the practice of psychology, the code of ethics as it is represented in the Board's Rules, and current professional standards and guidelines promulgated by the state and national organizations of psychologists. Relevant materials and references to sources will be provided.

q) **Temporary License Forms**. A careful reading of Rule 1180-2-.05 will help you determine if you need to apply for a Temporary License. If you are eligible and need this license, separate forms need to be completed by you and the person who will be supervising while you work under the Temporary License. Both forms need to be notarized. If you do not need a Temporary License, then do not submit this form.

When your file is administratively complete, reviewed by the Board and approved, your Temporary License will be issued. In the event an application is not approved, a refund of the Temporary License fee may be requested in writing. Allow 6-8 weeks for processing this refund.

r) **Provisional License Forms**. A careful reading of Rule 1180-2-.06 will help you determine if you need to apply for a Provisional License. This license is required for anyone completing a post-internship, post-doctoral supervised year of experience in Tennessee. If you are eligible and need this license, separate forms need to be completed by you and the person who will be supervising you while you work under the Provisional License. Both forms need to be notarized and submitted with the Provisional License fee. If you do not need a Provisional License, then do not submit this form.

When your file is administratively complete, reviewed by the Board and approved, your Provisional License will be issued. You may begin working toward your 1900 post-doctoral supervised hours once your receive this Provisional License. In the event an application is not approved, a refund of the Provisional License fee may be requested in writing. Allow 6-8 weeks for processing this refund.

s) **Licensure Endorsement Form.** Please provide each person writing a letter of recommendation with a copy of this form and ask that the completed form accompany the recommendation letter. **Rule 1180-2-.03 details the credentials of the individuals writing letters of recommendation.**

Be aware that it is essential that you request references from individuals who have personal knowledge of, and can attest to, your education, training and performance. All letters shall be current (attesting to current or recent work), original letters on professional letterhead written specifically for this licensure application and mailed directly to the Board by the person providing the information. Such letters are valid for one year from date of receipt. **Make certain that the psychologists writing your letters clearly indicate that they are endorsing you as a Psychologist or Psychologist with HSP designation**. They should also avoid using a letter already written for a job application. The Board may initiate inquiries if additional information is needed.

t) The **Postdoctoral Supervised Experience Documentation Form.** This form provides the board with verification that your post-doctoral year of supervised experience has been completed and it should not be submitted to the board until you have finished the required 1900 hours. A careful reading of Rule 1180-2-.02 and 1180-2.03 should be helpful in understanding the requirements for this year of supervised experience. The form needs to be signed by both you and your supervisor and it must be notarized. If you accumulated your 1900 hours at more than one location, please provide the information on a copy of this form.

Checklist

You send	You request others to send
___ Signed & notarized application	____ Official transcripts
___ Notarized or Certified Copy of Birth Certificate	____ 3 Recommendation Letters with Endorsement Forms
___ 2 signed passport photographs	____ Verification of Licensure, if Licensed in other Jurisdiction regardless of the status of the license (i.e., inactive)
___ Temporary License Application (if applicable)	___ Letter from Internship Director
___ Temporary License. Supervisor Affidavit (if needed)	___ Criminal Background Check
___ Provisional License Application (if applicable)	
___ Provisional License Supervisor Affidavit (if needed)	
___ Completed Mandatory Practitioner Profile Questionnaire **(mail with the application)**	
___ Postdoctoral Supervised Experience Documentation Form (if applicable)	
___ Check or money order for all applicable fees	

1410-001 -	$175.00
1410-001 -	$200.00
1410-006 -	$10.00
1410-001 -	$200.00
1410-001 -	$100.00
	$685.00

STATE OF TENNESSEE
DEPARTMENT OF HEALTH
HEALTH RELATED BOARDS
227 FRENCH LANDING, SUITE 300
HERITAGE PLACE METRO CENTER
NASHVILLE, TN 37243

BOARD OF EXAMINERS IN PSYCHOLOGY

Psychologist Application

1. Name _____
   Last First Middle Maiden

2. Full Mailing Address (This address will be published on license verification web page.)

   _____

   _____

   _____

3. Type of license sought (check one) _____ Psychologist
   _____ Psychologist with Health Service Provider Designation

4. Are you apply for a Temporary license? _____ Yes _____ No

5. Are you applying for a Provisional license? _____ Yes __ No

6. Social Security Number _____

7. Date of Birth _____
   Month / Day / Year

8. Sex _____ Male _____ Female (For statistical purposes only.)

9. Place of Birth _____
   City or County State Country

10. Citizenship _____ Native Born US Citizen
    _____ Naturalized US Citizen _____
    Cert. No. Year Court
    _____ Other (please describe on additional sheet.)

11. Telephone Numbers Home _____

    Work _____

    Fax _____

12. E-Mail Address _____

		Yes *	No
13.	Have you ever taken the Examination for Professional Practice in Psychology?	___	___
14.	Have you ever been denied a license or certificate to practice psychology?	___	___
15.	Have you ever had a license or certificate for the practice of any profession, including Psychology, revoked, suspended, placed on probation or restrictions, or received a letter of reprimand?	___	___
16.	Have you ever been convicted of a felony?	___	___
17.	Have you ever been convicted of drunkenness or violation of the narcotic laws?	___	___
18.	Have you ever been convicted for any offense involving moral turpitude?	___	___
19.	Have you ever been charged with an ethics violation by any professional or scientific society?	___	___
20.	Have you ever had your membership in any professional or scientific organization revoked or suspended for any reason other than non-payment of dues/	___	___
21.	Have you ever had clinical or staff privileges revoked or suspended?	___	___
22.	Have you ever had professional liability insurance canceled?	___	___

***** On a separate sheet provide details relevant to any "yes response. Please note relevant dates.

23. If you hold, or have ever held, a license/certificate to practice psychology, please list.

State(s)	Level of Licensure	Specialty (If applicable.)	License Number	Date Issued	Active Yes/no

24. Recommendation letter writers

Full name License # Licensing Jurisdiction

_____

_____

_____

25. Graduate Training in Psychology

Department & program name _____

Program address _____

_____

Degree received _____ Major Professor _____

Dates of attendance from _____ (month/year) to _____ (month/year)

During the time you attended this doctoral program was it	Yes	No
Accredited by APA's Committee on Accreditation?	___	___
Listed in the NR/ASPPB's Designated Doctoral Programs in Psychology?	___	___

26. Predoctoral Internship in Psychology

Internship name _____

Internship address _____

_____

_____

Internship Director's Name _____

Dates of attendance from _____ (month/year) to _____ (month/year)

During the time you attended this internship program was it	Yes	No
Accredited by APA's Committee on Accreditation?	___	___
A member of APPIC?	___	___

27. Postdoctoral Supervised Experience

Facility name _____

Type of facility _____

Facility address _____

Supervisor name License # Licensing Jurisdiction

_____

Dates of post-doctoral experience _____ (month/year) to _____ (month/year)

Hours worked per week	_____
Number of face-to-face client contact hours per week.	_____
Number of face-to-face individual supervision hours per week	_____
Number of group supervision hours per week	_____

Describe types of clients served and psychological services delivered

_____

_____

28. Previous Mental Health Related Employment

Employer's name _____

Type of facility _____

Facility address _____

_____

Your job title _____

Dates of employment _____(month/year) to _____(month/year)

Describe types of clients served and psychological services delivered

_____

_____

Supervisor's name & position _____

Supervisor's licensure status _____

29. Please attach signed passport style photograph in the space below.

"I authorize, whenever it may be deemed necessary by the Board of Examiners in Psychology, the obtaining of information concerning my candidacy from organizations such as the Committee on Scientific and Professional Ethics and Conduct of the American Psychological Association, the Executive Secretary of the American Psychological Association, and/or any other state psychological association, the officers of any board that grants diplomas, certificates or license in the field of psychology, the officers of any association of psychologists and the faculty of any college or university attended."

I, _____, solemnly swear that the statements on this application are true and correct. In signing this affidavit, I am aware that Chapter 9, Public Acts of 1947, provides that a person filing a forged affidavit of identification is subject to punishment prescribed by law for the crime of forgery.

_____
Signature of Applicant

Subscribed and sworn before me this _____day of _____, _____
in _____, _____
City State

_____ My commission expires _____
Notary

State of Tennessee
Department of Health
Board of Examiners in Psychology

Temporary Psychologist License Application

The Temporary License will allow the applicant to perform the functions specified in T.C.A. § 63-11-203 only under qualified supervision. Statutory requirements for a Temporary License can be found in T.C.A. § 63-11-206 and detailed in section 1180-2-.05 of the Board Rules. Applicants for this license need to supply to the Board a completed, notarized application, a notarized Supervisor Affidavit, and required fees. If granted the Temporary License is valid for one year.

1. Name _____
   Last First Middle Maiden

2. Type of license sought (check one) _____ Psychologist
   _____ Psychologist with Health Service Provider Designation

3. Social Security Number _____

4. Have you ever been issued a temporary license to practice psychology in Tennessee? ____ Yes ____ No

5. Have you within the last year failed the Examination for Professional Practice in Psychology? ____ Yes ____ No

   If yes, provide date(s) _____

6. Have you within the last year failed the Oral Exam for licensure as a psychologist or psychological examiner in Tennessee? ____ Yes ____ No

   If yes, provide date(s) _____

I, _____ solemnly swear that the statements on this temporary license application are true and correct. In signing this affidavit, I am aware that Chapter 9, Public Acts of 1947, provides that a person filing a forged affidavit of identification is subject to punishment prescribed by law for the crime of forgery.

_____
Signature of Applicant

Subscribed and sworn before me this _____day of _____, _____

at _____, _____
City State

_____
Notary

My commission expires _____

State of Tennessee
Department of Health
Board of Examiners in Psychology

Temporary Psychologist License Application
Supervisor Affidavit

The Temporary License will allow the applicant to perform the functions specified in T.C.A. § 63-11-203 only under qualified supervision. Statutory requirements for a Temporary License can be found in T.C.A. § 63-11-206 and detailed in section 1180-3-.05 of the Board Rules. Applicants for this license need to supply to the Board a completed, notarized application, a notarized Supervisor Affidavit, and required fees. If granted the Temporary License is valid for one year.

_____ has applied for a Temporary Psychology license. I will have the responsibility for direct supervision of psychological services delivered by the above named applicant during the tenure of his/her Temporary License in accordance with Standards of Supervision in the current Board Rules.

The applicant will provide psychological services at the following locations:

_____

_____

Describe the types of clients that will be seen and services that will be provided.

_____

_____

_____

_____
Signature of Supervisor

_____
Print Name of Supervisor

_____
Tennessee License Number

NOTE: No Temporary License will be issued until this form is completed and received in the Board office. Should the applicant's Temporary License expire, both the supervisor and the applicant will be notified by the Board within ten (10) days.

_____
Area of Competency/Health Services Provider

Subscribed and sworn before me this ____ day of _____, _____.

(SEAL)

_____
Notary's Signature

My commission expires: _____

State of Tennessee
Department of Health
Board of Examiners in Psychology

Provisional Psychologist License Application

The Provisional License will allow the applicant to perform the functions specified in T.C.A. § 63-11-203 only under qualified supervision. Statutory requirements for a Provisional License can be found in T.C.A. § 63-11-206 and detailed in section 1180-2-.06 of the Board Rules. Applicants for this license need to supply to the Board a completed, notarized application, a notarized Supervisor Affidavit, and required fees. If granted the Provisional License is valid for one year.

1. Name _____
Last First Middle Maiden

2. Social Security Number _____

The applicant will provide psychological services at the following location.

_____

_____

Describe the types of clients that will be seen and services that will be provided.

_____

_____

_____

I, _____ solemnly swear that the statements on this Provisional License application are true and correct. In signing this affidavit, I am aware that Chapter 9, Public Acts of 1947, provides that a person filing a forged affidavit of identification is subject to punishment prescribed by law for the crime of forgery.

_____
Signature of Applicant

Subscribed and sworn before me this _____day of _____, _____
at _____, _____
City State

_____
Notary

My commission expires _____

State of Tennessee
Department of Health
Board of Examiners in Psychology

Provisional Psychologist License Application
Supervisor Affidavit

The Provisional License will allow the applicant to perform the functions specified in T.C.A. § 63-11-203 only under qualified supervision. Statutory requirements for a Provisional License can be found in T.C.A. § 63-11-206 and detailed in section 1180-2-.06 of the Board Rules. Applicants for this license need to supply to the Board a completed, notarized application, a notarized Supervisor Affidavit, and required fees. If granted the Provisional License is valid for one year.

_____ has applied for a Provisional Psychology License. I will have the responsibility for direct supervision of psychological services delivered by the above named applicant during the tenure of this Provisional License in accordance with Standards of Supervision in the current Board Rules.

The applicant will provide psychological services at the following locations.

_____

_____

Describe the types of clients that will be seen and <u>services</u> that will be provided.

_____

_____

_____

_____
Signature of Supervisor

NOTE: No Provisional License will be issued until this form is completed and received in the Board office. Should the applicant's Provisional License expire, both the supervisor and the applicant will be notified by the Board within ten (10) days.

_____
Print Name of Supervisor

_____
Tennessee License Number

_____
Area of Competency/Health Services Provider

Subscribed and sworn before me this ____ day of _____, _____.

(SEAL)

_____
Notary's Signature

My commission expires: _____

State of Tennessee
Board of Examiners in Psychology
Psychologist Application
Licensure Endorsement Form

Date _____

Applicant's Name _____

Endorser's Name _____

Endorser"s License _____

Endorser"s City and State _____

If licensed, is license active? _____ Yes _____ No

Is endorser licensed as a Health Services Provider? _____ Yes _____ No

Is endorser listed in the National Register? _____ Yes _____ No

Is endorser ABPP? _____ Yes _____ No

Please list specialty. _____

In your accompanying letter (on your letterhead), please describe in detail the nature of your relationship with the applicant, the dates of contact with the applicant, and the basis of your knowledge of the applicant's suitability to practice psychology such as the quality of the applicant's performance, education and training, experience, ethics and character. As endorser, you will have personal knowledge of and attest to the applicant's competency in the areas above. Mail your letter directly to the Board of Examiners in Psychology.

Please indicate which of the following best reflects your opinion of the applicant's application for licensure.

_____ Recommended without Reservation

_____ Recommended with Reservation

_____ Not recommended

To ensure timely receipt of materials, all information is to be addressed as follows:

Board of Examiners in Psychology
227 French Landing, Suite 300
Heritage Place Metro Center
Nashville, TN 37243

State of Tennessee
Board of Examiners in Psychology
Verification of Licensure
Certification from Other State Boards

I am applying for a Tennessee Psychology License. I was granted license # _____ on _____ (date) by the State of _____. The Tennessee State Board of Examiners in Psychology requests that I submit evidence that my license in the State of _____ is in good standing. You are hereby authorized to release any information in your files, favorable or otherwise, directly to the Tennessee State Board of Examiners in Psychology. Your early attention is appreciated.

Applicant's Signature _____

Applicant's Name _____ License # _____

Executive Office of State Board

Please complete and return form to:

Board of Examiners in Psychology
227 French Landing, Suite 300
Heritage Place Metro Center
Nashville, TN 37243

Licensed by _____ EPPP _____ State exam _____ Reciprocity _____ other (Please explain.)

If licensed by EPPP examination, please provide the following information

Raw score	_____		Percentile	_____		National mean	_____
Percent score	_____		Exam Date	_____		Standard deviation	_____

If licensed, is license current? _____ Yes _____ No

If **no**, please explain. _____

_____

If licensed, does the individual's file contain any derogatory Information? _____ Yes _____ No

If **yes**, please explain. _____

_____

Is there any other information pertinent to this license? _____ Yes _____ No

If **yes**, please explain. _____

_____

_____
State Board

(Seal)

_____
Authorized Signature

_____
Title

_____
Date

State of Tennessee
Board of Examiners in Psychology
Postdoctoral Supervised Experience
Documentation Form

1. Applicant Name _____
   Last First Middle Maiden

2. Social Security # _____

3. TN Provisional License # _____ Date Issued _____

4. Other Psychology License _____ State Issued _____

   Date Issued _____ Current? Yes No

5. List the name and address of the facility where you provided psychological services during the postdoctoral supervised experience.

   _____

   _____

   _____

5. What type of facility was this? (e.g., Community Mental Health Center, Hospital, etc.).

   _____

   _____

   _____

6. Provide a description of the types of <u>clients seen and services</u> provided during the postdoctoral supervised experience.

   _____

   _____

   _____

7. What was your title? _____

8. Month and year experience started _____ completed _____

9. What was the average number of hours per week that you worked? _____

10. What was the number of hours of direct, individual face-to-face supervision per week? _____

11. Name and Degree of Supervisor _____

    License number _____ State of License _____

Supervisor's Title _____

Is Supervisor licensed as a Health Service Provider? Yes No

If not, what was the Supervisor's license designation? _____

12. What was the total number of postdoctoral supervised hours completed? _____

13. What was the total number of hours of supervision? _____

I hereby attest that all the above information is true and correct to the best of my knowledge.

_____ _____
Signature of Supervisor Date

_____ _____
Print Name of Applicant Date

Subscribed and sworn before me this ____ day of _____, _____.

(SEAL) _____
Notary's Signature

My commissioner expires: _____

VERIFICATION OF PRE-DOCTORAL INTERNSHIP

If you are applying for licensure as a psychologist with designation as a Health Service Provider, you must have successfully completed an Internship. Please complete the top portion of this form and have the director of your internship complete the verification portion and mail it directly to the Board. This form is considered part of your application; therefore, your file will not be reviewed if you are applying for licensure as a psychologist with Health Service Provider designation until this form is in your file. A notarized copy of a signed serialized certificate of completion of an APA approved predoctoral internship in professional psychology may be sent in lieu of the Internship Director Verification form.

I am applying for a license to practice as a psychologist in Tennessee. The Tennessee Board of Examiners in Psychology requires that I submit evidence of successful completion of an internship. Please complete the form and return it to:

Board of Examiners in Psychology
227 French Landing, Suite 300
Heritage Place Metro Center
Nashville, TN 37243

You are hereby authorized to release any information, favorable or otherwise, directly to the Tennessee Board of Examiners in Psychology. Your prompt attention will be appreciated.

Signature:_____

Print or type name: _____

****

Credentials of Director (to be completed by director)

This is to certify that I was the training director of the internship for _____
(applicant's name)

and the following information is true and complete to the best of my knowledge.

Your name: _____
(Signature)

Print or type name: _____

Office Address: _____

_____

_____

Your highest degree: _____

Are you licensed as a psychologist? Yes _____ No _____

State(s) and license number(s): _____

What specialty designation if any? _____

Are you in the National Register of Health Service Providers in Psychology? Yes _____ No _____

Are you a fellow/diplomat of ABPP? Yes _____ No _____

If yes, specialty: _____

What is your title within your organization? _____

Internship Information:

Person supervised: _____

Title and location of Internship: _____

APA approved: Yes _____ No _____

Listed in the Directory of Internships for Doctoral Students in School Psychology (until December 31, 1999).
Yes _____ No _____

APPIC listed: Yes _____ No _____

Number of Internship hours: _____

Date Internship began: _____ Date Internship ended: _____

If the internship described was APA approved or APPIC listed – stop at this point and return this entire

form to the Board of Examiners in Psychology.

BE SURE TO SIGN THE LAST PAGE OF THIS SECTION
What percentage of the total Internship hours does this represent? _____

How many hours (per week) were spent in regularly scheduled, formal face-to-face individual supervision with a psychologist, dealing with the psychological services rendered by the intern? _____

Was the Internship training post-clerkship and post-practicum? Yes _____ No _____

How many Interns were present during the trainee's training period? _____

Is there a written state or brochure describing the goals and content of the Internship and expectations regarding the trainee's work available to intern applicant? Yes _____ No _____

_____ successfully
(Name of Candidate)

completed this Internship: _____.
(Date)

_____
Signature

_____
Title

MS/G4013177/BPE

TENNESSEE DEPARTMENT OF

HEALTH

MANDATORY

PRACTITIONER

PROFILE QUESTIONNAIRE

PURSUANT TO TENNESSEE CODE ANNOTATED SECTION 63-51-101 et seq, LAWS OF TENNESSEE

FOR

LICENSED HEALTH CARE PROVIDERS

FOREWORD

The Health Care Consumer Right-to-Know Act of 1998, T.C.A. § 63-51-101 et seq, requires designated licensed health professionals to furnish certain information to the Tennessee Department of Health. The information specified in the law is contained in the attached questionnaire. From the information submitted, the Department will compile a practitioner profile which is required to be made available to the public via the World Wide Web and toll-free telephone line after May 1, 1999. Each practitioner who has submitted information must update that information in writing by notifying the Department of Health, Healthcare Provider Information Unit, within 30 days after the occurrence of an event or an attainment of a status that is required to be reported by the law. A copy of your initial or updated profile will be furnished to you for your review prior to publication. That opportunity will allow you to make corrections, additions and helpful explanatory comments. Failure to comply with the requirement to submit and update profiling information constitutes a ground for disciplinary action against your license. A blank copy of the profile may be obtained from the following web site address: http://tennessee.gov/health**.**

On the department's homepage, under Licensing, click on "Health Professional Boards"; then select the appropriate board.

TABLE OF CONTENTS

SECTION I: GENERAL INSTRUCTIONS

- **Read all instructions thoroughly before completing the profile questionnaire. Incomplete or omitted information may delay meeting the mandatory reporting requirement.**
- **Incomplete or illegible profiles will be returned to the provider for resubmission.**
- **Some questions do not apply to every profession. If a question does not apply to you, indicate so by checking the "Does not apply" box.**
- **Provide only information for the previous ten (10) years where indicated on the questionnaire.**
- **Complete the questionnaire and attachments by typing or printing your response in block letters in ballpoint pen. Incomplete or illegible profiles will be returned to the provider for resubmission. Some questions do not apply to every profession. If a question does not apply to you, indicate so by checking the "Does not apply" box.**
- **DO NOT RETURN THESE INSTRUCTIONS WITH THE QUESTIONNAIRE TO THE DEPARTMENT.**
- **You may have completed a similar questionnaire for another state's licensing board. If so, Tennessee law still requires you to complete and submit this form.**
- **If you have an active Tennessee license you are required to complete the questionnaire. This includes those practitioners who are retired or no longer practicing.**

- **Mail the completed ORIGINAL profile questionnaire <u>within thirty (30) days of its receipt by the provider</u> to:**

Healthcare Provider Information Manager
Tennessee Department of Health
Division of Health Related Boards
227 French Landing, Suite 300
Heritage Place Metro Center
Nashville, TN 37243
1-800-778-4123
Local - (615) 532-3202

- **<u>Keep a copy of the questionnaire for your records.</u>**

✓CHECKLIST

Before you mail your questionnaire:

- ☐ Have all questionnaire and supplemental pages been completed with the name of the practitioner, profession and license number at the top of the page?

- ☐ Have supplemental pages been clearly labeled with the corresponding question for which the response is being provided?

- ☐ Have you retained a copy of your signed questionnaire?

SECTION II:

COMPLETING THE PROFILE QUESTIONNAIRE

QUESTIONNAIRE DEADLINE

The provider must submit the questionnaire on or before thirty (30) days from its receipt.

COMPLETING THE FORMS

Complete all forms by printing neatly in block letters in ballpoint pen or typing the information. If a question does not apply to you, indicate so by checking the "Does not apply" box. **Illegible questionnaires will be returned.**

The following numbered parts correspond to the matching number on the questionnaire form.

I. PRACTITIONER DATA

Complete part one (1) noting the following:

- License number: Fill in your license number and indicate your profession in the space provided.
- Social security number: **Your social security number will not be published or in any way given out to the public. It is required for in-house tracking purposes only.**
- Address: Complete mailing and practice address (if applicable). Retirees: Write in "N/A" for practice address.

II. GRADUATE/POSTGRADUATE MEDICAL/PROFESSIONAL EDUCATION AND TRAINING

List chronologically all medical/health professional related graduate/postgraduate education and training completed. Exclude any program or courses taken to satisfy continuing education requirements for licensure renewal. Provide information about health related degrees you have received including your licensure degree.

III. SPECIALTY BOARD CERTIFICATIONS

Provide information on any certification, specialty or subspecialty from any specialty board recognized by the American Medical Association, American Osteopathic Medical Association, American Podiatry Association, American Chiropractic Association, American Dental Association or any other specialty certifying body as determined by your Tennessee licensing board.

IV. FACULTY APPOINTMENTS

Answer ALL yes/no questions with a “yes” or “no” response. A brief statement in the space provided should follow a "yes" answer. If the space is insufficient for your response, attach an additional page, being sure to number the response to match the appropriate question.

V. STAFF PRIVILEGES

List all hospitals at which you hold staff privileges. This includes:

- Licensed hospitals-this term is defined at T.C.A. § 68-11-201.

In the spaces provided, answer information about the TennCare plans in which you participate, if any. If there are more than five (5), please send attachment.

VI. FINAL DISCIPLINARY ACTION

These questions refer to final disciplinary or adverse actions taken within the previous **ten (10) years**, whether in this state or any other jurisdiction. The term **final** means the matter was fully adjudicated at a hearing and the appeal’s period expired, or that the applicable board issued an agreed order or consent decree.

In the “Description of Violation” spaces, indicate the nature of the conduct in question such as malpractice, unethical conduct, drug-related, sex related, impairment, fraud, etc.

In the “Description of Action” spaces, indicate the type of disciplinary action imposed against your professional license.

The term **disciplinary action** includes, but is not limited to:

- Probation
- Limitation/Restriction
- Suspension
- Revocation
- Voluntary relinquishment in lieu of disciplinary action
- Any other adverse action taken against a license or privilege by a medical/health related institution
- Compulsory surrender of license or privilege
- Civil or other monetary fine or penalty
- Resignation from or non-renewal of medical staff membership at a hospital in lieu of, or in settlement of, a pending disciplinary case related to competence or character
- Restriction of privileges in lieu of, or in settlement of, a pending disciplinary case related to competence or character

If you answer “yes” to any of the questions in this section and if the action is under appeal, you must attach a copy of the notice of appeal. Note: You must submit a copy of the final written order of

disposition immediately after the appeal is disposed of by the adjudicating authority. Please read questions VII B and C in their entirety before answering those questions.

VII. CRIMINAL OFFENSES

This part requires you to report any state or federal felony criminal offense convictions. It also requires the reporting of misdemeanor offenses, regardless of classification, in which any element of the offense involves sex; alcohol or drugs; physical injury or threat of injury to any person; abuse or neglect of any minor, spouse or the elderly; fraud or theft in Tennessee or another jurisdiction; or unlicensed practice of a profession within the most recent ten (10) years. If you answer "yes" to this question and the offense is under appeal, you must submit a copy of the notice of appeal of that criminal offense. Immediately upon disposition of the appeal, you must submit a copy of the final written order of disposition. If any misdemeanor conviction reported is expunged, a copy of the order of expungement signed by the judge must be submitted to the Department before the conviction will be removed from any profile.

VIII. LIABILITY CLAIMS

This section requires you to indicate all medical malpractice court judgments, arbitration awards, or settlements in which a payment was awarded to a complaining party beginning with judgments or settlements entered or executed after May 19, 1998. That means if the act or event leading to the claim occurred in, for instance, 1995, but was finally adjudicated against you after May 19,1998, you must indicate that claim in the space provided. JUDGMENTS OR SETTLEMENTS BELOW THE THRESHOLD AMOUNT ESTABLISHED BY YOUR TENNESSEE LICENSING BOARD ARE NOT REQUIRED TO BE SUBMITTED. To find out the threshold amount established by your board, consult your board's web page at www.state.tn.us/health/ or call 1-800-778-4123. Pending malpractice claims are not required to be reported unless/until final adjudication against you.

IX. OPTIONAL INFORMATION

This section is voluntary. You may list, briefly describe, and submit any information/documentation regarding your professional practice in the spaces provided. Attach an additional sheet labeled with the question number if additional space is required.

Practitioner's Name _____ **License #** _____
Profession _____

SECTION III:

HEALTHCARE PROVIDER INFORMATION MANAGER
TENNESSEE DEPARTMENT OF HEALTH
DIVISION OF HEALTH RELATED BOARDS
227 FRENCH LANDING, SUITE 300
HERITAGE PLACE METRO CENTER
NASHVILLE, TENNESSEE 37243

I. PRACTITIONER DATA

A. PROFESSIONAL LICENSE NUMBER: _____ PROFESSION: _____

B. SOCIAL SECURITY NUMBER: _____ (**This will not be published as part of the profile or website).**

C. NAME (INCLUDE MAIDEN AND ON 2ND/3RD LINES ANY ALIASES, IF APPLICABLE):
CURRENT NAME:

_____
(LAST) (FIRST) (MIDDLE AND MAIDEN NAME) (IF APPLICABLE)

FORMER NAME(S):

_____
(LAST) (FIRST) (MIDDLE)

_____
(LAST) (FIRST) (MIDDLE)

D. MAILING ADDRESS:

_____
(STREET AND NUMBER)

_____
(CITY) (STATE) (ZIP CODE)

PRIMARY PRACTICE ADDRESS: (This will be published as part of the profile and the web site).

_____
(PRACTICE NAME)

_____
(STREET AND NUMBER)

_____
(CITY) (STATE) (ZIP CODE)

E. TELEPHONE:(_____)_____**(This will not be published as part of the profile or the web site).**

F. LANGUAGES, OTHER THAN ENGLISH: Indicate languages other than English or translation services that may be available at your primary practice location.

1. _____
2. _____

G. SUPERVISING PHYSICIAN: If you are required by law to be supervised by a physician (physician assistant or nurse practitioner) indicate the name(s) and address(es) of each supervising physician. If you need more space, attach additional sheets:

1. _____
2. _____

Practitioner's Name _____ **License #** _____
Profession _____

II. GRADUATE/POSTGRADUATE MEDICAL/PROFESSIONAL EDUCATION AND TRAINING

A. What school(s)/educational programs have you attended? And, what type(s) of degree(s) do you hold? Do not include coursework taken to meet the continuing education requirement for licensure renewal. (Authority: T.C.A. §63-51-105(a)(6) and (7))

PROGRAM/INSTITUTION	CITY/STATE/ COUNTRY	DATE OF GRADUATION	TYPE OF DEGREE
1.			
2.			
3.			
4.			
5.			
6.			

B. List in chronological order from date of graduation to the present, all completed medical/professional graduate and/or post-graduate training (internship, residency, fellowship or other program). Do not include coursework taken to meet continuing education requirements for licensure renewal. (Authority: T.C.A. § 63-51-105(a)(6))

PROGRAM AND SPECIALTY AREA (INTERNSHIP, RESIDENCY, FELLOWSHIP, ETC.)	LOCATION OF TRAINING (CITY,STATE, COUNTRY)	FROM MM/DD/YYYY	TO MM/DD/YYYY
1.			
2.			
3.			
4.			

Practitioner's Name _____ **License #** _____
Profession _____

III. SPECIALTY BOARD CERTIFICATIONS

Do you hold a certification, specialty or subspecialty from any specialty board recognized by the board regulating the profession for which you are licensed? (see instructions) (Authority: T.C.A. § 63-51-105(a)(8)) If "Yes", complete section below. YES ❒ NO ❒

CERTIFYING BODY/BOARD INSTITUTION	CERTIFICATION/SPECIALTY/SUBSPECIALTY
1.	
2.	
3.	
4.	
5.	

IV. FACULTY APPOINTMENTS

A. Have you had the responsibility for graduate medical education within the last ten (10) years? (Authority: T.C.A. § 63-51-105(a)(10)) YES ❒ NO ❒

B. Do you currently hold a faculty appointment at a medical/health related institution of higher learning? (Authority: T.C.A. § 63-51-105(a)(10)) YES ❒ NO ❒

If "YES", list the title of the appointment and name(s) and city/state of institution(s). (Attach additional sheets, clearly labeled with this question number, if necessary.)

	TITLE	INSTITUTION	CITY/STATE
1.			
2.			
3.			
4.			

V. STAFF PRIVILEGES

A. Do you currently hold staff privileges at a hospital? (Authority: T.C.A. §63-51-105(a)(a)) YES ❒ NO ❒

If "YES", list each hospital at which you currently have staff privileges: (Attach additional sheets, clearly labeled with this question number, if necessary)

	Name of Hospital	City/State
1.		
2.		
3.		
4.		
5.		

Practitioner's Name _____ **License #** _____
Profession _____

B. Do you currently participate in any TennCare plan? (Authority: T.C.A. § 63-51-105(a)(16)) YES ❒ NO ❒
If "YES", list each plan in which you currently participate:

Name of TennCare Plan
1.
2.
3.
4.
5.

VI. FINAL DISCIPLINARY ACTION (See Instructions)

A. Within the previous ten (10) years, have you ever had any final disciplinary action taken against you by the agency regulating your license, in this state or any other jurisdiction? (Authority: T.C.A. § 63-51-105(a)(8)) YES ❒ NO ❒

If "YES", list name(s) and address(es) of agency(s) and a brief description of the final disciplinary action(s) and stated reason(s) for taking the action. (Attach additional sheets, clearly labeled with this question number, if necessary.)

	AGENCY NAME	DATE	DESCRIPTION OF VIOLATION	DESCRIPTION OF ACTION
1.				

IF "YES", is this final disciplinary action under appeal? (attach copy of notice of appeal) YES ❒ NO ❒

2.				

IF "YES", is this final disciplinary action under appeal? (attach copy of notice of appeal) YES ❒ NO ❒

3.				

IF "YES", is this final disciplinary action under appeal? (attach copy of notice of appeal) YES ❒ NO ❒

Practitioner's Name_____ **License #**_____
Profession _____

B. Within the previous ten (10) years, have you ever had your hospital privileges revoked or involuntarily restricted for reasons related to competence or character by the hospital's governing body? (Authority: T.C.A. § 63-15-105(a)(4)) YES ❒ NO ❒

If "YES", list name(s) and address(es) medical institution(s) and a brief description of the final disciplinary action(s) and stated reason(s) for the action. (Attach additional sheets, clearly labeled with this question number, if necessary)

	HOSPITAL NAME	DATE	DESCRIPTION OF VIOLATION	DESCRIPTION OF ACTION
1.				

IF "YES", is this final disciplinary action under appeal? (attach copy of notice of appeal) YES ❒ NO ❒

2.				

IF "YES", is this final disciplinary action under appeal? (attach copy of notice of appeal) YES ❒ NO ❒

3.				

If "YES", is this final disciplinary action under appeal? (attach copy of notice of appeal) YES ❒ NO ❒

C. Within the previous ten (10) years, have you ever been asked to or allowed to resign from or had any medical staff privileges restricted or not renewed by <u>any</u> hospital in lieu of or in settlement of a pending disciplinary action related to competence or character? (Authority: T.C.A. § 63-51-105(a)(4)) YES ❒ NO ❒

If "YES", list name(s) and address(es) of the hospital(s) and a brief description of the final disciplinary action(s) and stated reason(s) for the action. (Attach additional sheets, clearly labeled with this question number, if necessary)

	HOSPITAL NAME	DATE	DESCRIPTION OF ACTION
1.			

IF "YES", is this final disciplinary action under appeal? (attach copy of notice of appeal) YES ❒ NO ❒

2.			

IF "YES", is this final disciplinary action under appeal? (attach copy of notice of appeal) YES ❒ NO ❒

3.			

If "YES", is this final disciplinary action under appeal? (attach copy of notice of appeal) YES ❒ NO ❒

Practitioner's Name_____ **License#**_____
Profession _____

VII. CRIMINAL OFFENSES (See Instructions)

Have you within the most recent ten (10) years, been found guilty, regardless of whether adjudication of guilt was withheld, or pled guilty or nolo contendere to a criminal misdemeanor or felony in any jurisdiction? (Authority: T.C.A. § 63-15-105(a)(1))

If "YES" briefly describe the offense(s): YES ❒ NO ❒

	DESCRIPTION OF OFFENSE	DATE	JURISDICTION
1.			
	If "YES", is this conviction under appeal? (attach copy of notice of appeal)		YES ❒ NO ❒
2.			
	If "YES", is this conviction under appeal? (attach copy of notice of appeal)		YES ❒ NO ❒
3.			
	If "YES", is this conviction under appeal? (attach copy of notice of appeal)		YES ❒ NO ❒

VIII. LIABILITY CLAIMS

Have you had a medical malpractice court judgment, arbitration award, or settlement against you since May 19, 1998? (Authority: T.C.A. §63-51-105(a)(5)) If "YES", indicate the date of claim(s) and the amount of judgment(s), award(s) or settlement(s).

	ENTRY DATE OF DISPOSITION ORDER OR SETTLEMENT	AMOUNT
1.		
2.		
3.		

IX. OPTIONAL INFORMATION

A. PUBLICATIONS: List any publications you have authored in peer-reviewed medical literature: (optional) (Authority: T.C.A. § 63-15-105(a)(11))

	TITLE	PUBLICATION	DATE
1.			
2.			
3.			
4.			

B. PROFESSIONAL OR COMMUNITY SERVICE ACTIVITIES AWARDS: List any information regarding professional or community service associates, activities and awards: (optional) (Authority: T.C.A. § 63-15-105(a)(12))

	COMMUNITY SERVICE/AWARD/HONOR	**ORGANIZATION**
1.		
2.		
3.		
4.		

I affirm these statements are true and correct and recognize that providing false information may result in disciplinary action against my license pursuant to T.C.A. § 63-51-113 and/or 63-51-118.

_____ Date:_____
(Signature of Provider)

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